Regulations Review for 10.07.02 (Sections .01-.12)

Subject: Regulations Review 10.07.02 (Sections .01-.12)

Hosts: Amanda Thomas (Organizer), Regulatory Affairs Analyst, OHCQ
Chrissy Vogeley, Chief of Staff, OHCQ
Gwen Winston, Quality Initiatives Coordinator, OHCQ
Jasmin Watson-El, Executive Associate, Office Of Health Care Quality
Margie Heald, Deputy Director of Federal Programs, OHCQ
Sandy Brownell, Chief Nurse, OHCQ
Patricia Tomsko Nay, Executive Director, OHCQ

Date: October 9, 2014

Place: OHCQ (Conference Room #1, Office of Health Care Quality)

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*This is the first session to review 10.07.02 (sections .01-.12) of LTC Regulations

I. Welcome

Dr. Nay welcomed everyone to the session and thanked them all for coming. OHCQ introduced staff and opened the floor to have stakeholders introduce themselves and the organizations (if applicable) they represent.

Attendees :

Anne Arrington (Carroll County Bureau of Aging)
Anne Hurley (Maryland Legal Aid)

Benjamin Woolery
Clare Whitbeck (VOICES)
Danna Kauffman (LifeSpan)
Eileen Bennett (MD Culture Change Coalition)
Will Schumann
Joyce Wolpert
Kim Burton (Mental Health Association of Maryland)
Lynn McCamie (Dept. of Aging Ombudsman program)
Marie Savage (Maryland Board of Dietetic Practice)
Mary Jones
Michele Blackwell
Michele Douglas (Public Policy Partners)
Neal Karkhanis (Health Facilities Association of Maryland)
Philip Cronin
Phyllis McShane (MD Dieticians and Health Care)
Sandra Iverson
Sandra Martin (OHCQ)
Sharlene Liberto
Stanley Weinstein (State Board of Social Work Examiners)
Susan Mondelo
Susan Panek (Maryland Medicaid Program)
Thomas Jones
Tracy Immel (Health Facilities Association of Maryland)
Victoria Woodruff

Additional Organizations Represented:
AA CO Ombudsman, Alzheimer's Association, Baltimore County Ombudsman, Elder Law Attorney, Health Facilities Association of MD, Image Center, Lifespan Longview Nursing, LTC Assistance Project Legal Aid, MD Academy of Nutrition and Dietetics, MD Board of Social Work, Maryland Dietitians in Health Care Communities: MD-DHCC, Maryland Department of Aging, Medicaid, Mental Health Association, Montgomery County Ombudsman, Northwest Neighbors, Pro Bono Advocate, University of Maryland Medical Center, VOICES

II. Regulation Review 10.07.02 (Sections .01-.12)

A.) Review of Ground Rules

- Amanda discussed the ground rules and use of tools for the session.

- Please keep comments to 2 minutes.
- Limit side conversations
- Please use the "bike rack" to take notes. The "bike rack" is similar to the use of a "parking lot", a place to store ideas. As someone is speaking, if an idea hits you, write it down and if time permits, share or turn it in at the end of the session.This is similar to the survey sent to collect feedback on the regulations. All responses received through the survey link are time and date stamped. This tool provides enhanced tracking and record keeping of comments received.
- OHCQ will post the meeting's minutes as well as a response to comments received through the survey link.

Questions prior to regulation review.

Question: Can this survey be put through the board of VOICES since I am just a representative?

Answer: Survey is open until Monday, October 13, 2014 at 5 p.m. to give everyone a chance to submit feedback and input on the regulations.

Question: The survey that posts Monday, is it just for the first set of regulations?

Answer: It is just for sections .01 through .12

**Please note that if you need a copy of the regulations, we have a few copies up front, so you may have to share. If you have a comment, please stand and wait to be called. You will have 2 minutes to speak. Then, we will go to the phones and everyone there will have their 2 minutes as well.

B.) Begin Regulation Comments

.01 - Definitions

- VOICES would like to see supported personnel which is a term that is used throughout with a better definition. It just says "Aide". It does not even say certified aide. Aide is not even defined. So it can be anyone that you put an "A" on the front of their jacket.
- No definition of bedside care. What is emergency dental care, because nursing home is only to provide emergency dental care - clinicians know but nursing home directors do not.

- Ombudsman definition - are you talking about the state or local ombudsman? In certain cases, it might make a difference.
- Legal aid - Thanks for definition of chemical and physical restraints. We highly approve of definitions and physician descriptions of protective devices.
- Definition for attending physician. There are a number of references to orders and actions and would like to see some clarification.
- NP and PA scope of practice definitions and services provided in regards to orders.
- Changing "dietetic service supervisor" to "certified dietary manager", if there is an ad for a CDM, you will not get any responses. Goal is certify after the person is hired, just need more time to accomplish the certification. Timeline is not sufficient.
- Clarification on what qualifies concurrent review with behavioral status. What triggers concurrent review?
- Opportunities for training for Infection Preventionist (IPs). Want to make sure that if someone is hired brand new, that there are more opportunities for training to become a certified IP.
- Definition of certified social worker is a limiting definition. It only limits to one category of licensure. It does not include certified clinical. Since behavioral health is included in responsibilities of the social work department, it should be expanded to LCSWC to have a larger pool of qualified people to provide the services.
- When mentioning dietician, it's a licensed dietitian in the state of MD, a similar definition as a registered nurse instead of saying qualified.
- Thank you for adding behavioral in with concurrent review. Consider having it say Physical, behavioral "OR" mental status. Right now it says "AND". That's for 13A and 13B, need to add behavioral in there as well.
- Please define behavioral.
- Definition of "other qualified person" - If you keep this definition, add to definition, operates under the supervision of a licensed dietician in order to assure safety and care of patients especially with the proposed expansion by CMS to allow licensed registered dietitians to write diet orders including total parenteral nutrition (IV nutrition orders).
- Medicaid would like to call LTC facilities not extended care or comprehensive care. These are archaic terms. Problem is that the terms are in statute.

- What do we call behavioral health? (dementia, brain injury, substance abuse, mental health issues, etc.) Potential for separate meeting next month to dive into this.

.06 New construction, conversion, alteration or addition

- Lifespan - section c - clarify "issued all required permits". Many times permits are not in until construction starts and scheduled according to the permit. Makes it look like you have to have all permits issued when sending notification to OHCQ. One way to clean it up may be to remove section 1. Keep 2 and D. But given "E", that seems to take care of concerns.
- Clarify timing for notification. -- OHCQ changed language to "documentation may include". We will continue to try to wordsmith.
- Can we be more specific in terms of when a permit is needed or notification needed? With modification and additions, be specific (e.g. do we need a notification to turn a patient room into a rec room?) Does that require notification? If you do not need a permit for a modification, you should not have to provide notification.
- For any capital expenditures, MHCC needs to be notified.
- Culture change building designs should be considered when making changes to buildings. Shouldn't be a waiver required for changes in culture change.

.07 - Administration and resident care

- Question around Asst Director of nursing vs. hiring of an administrator. OHCQ will make the language clearer. If DON becomes administrator, someone need to be moved into the DON position
- ID badges need to be visible at all times and turned to face forward. People who live in nursing homes have a difficult time knowing who comes in and out of their rooms. The fact that name tags are turned over handicaps residents from knowing who people are and what they do.
- ID badges having 16 point font and Sans Serif font – American Disabilities act rule refers to signage not IDs. Should not require industry wide ID changes. Overly prescriptive. So many facilities have name tags that are pinned. Name tags should just be “readily visible" and enforcement should be for facilities that show problems. It's not systemic and is there legislative authority? OHCQ may not have legislative authority to specify size and font.

- Employee training on cognitive impairment and mental illness—training requirements should be consistent with behavioral health requirements elsewhere--can talk about in proposed focus group for behavioral health.
- Information is not transferred properly between nurses and CNAs. Nurses know more details about patients than the many CNA. Need better documentation and transfer or care plans.
- Define supportive personnel - does this include dietary aides, support aides? Also, if they are credited for their time, there has to be a better defintion of supportive staff.

.07-1 Employee Training on Cognitive Impairment

- Benign neglect - nurses do not set out to harm but miss needs of patient. Like sitting a tray in front of a person who is unable to feed themselves and returning to pick up an uneaten tray. ---Current training for CNAs and GNAs does not adequately cover cognitive impairment care.
- More training requirements for ancillary staff. This adds to safety for patients. Chemical restraints' after effects are harmful as well. More monitoring time should be required for those under chemical restraint.
- Continuing education must continue after hiring of direct care staff. Many different populations are in the facilities, parameters should be in place for behavioral therapy to help reduce use of chemical restraint.
- Training should be resident-specific as well
- Patients are refused at facilities with locked units and those who advertise dementia care. Patients are "dumped" at places like University of MD. Is there legal recourse for advocates trying to place patients at these facilities that really are not trained to handle patients they advertise to? Are patients covered under the discrimination clause?
- Concern with not having enough people on the floor who are trained above physical health. People are not trained for quality of life issues. Training and STRONG OVERSIGHT is needed on quality of life side just as in physical health side.

.08 - Admission and discharge

- Under "A. Discrimination" -- use term behavioral. Take out word mental and the word handicapped (use disability) and can these be covered under one word, behavioral.
- Notification- 30 day written notice of changes and moves. People should be notified IMMEDIATELY of death. Requirement of reasonable time for

notification of death or transfer to hospital. Should have more specific requirement for PROMPT notification
- Remove the word mental and just talk about Behavioral health forconsistency purposes.

.09 - Resident Care Policies

- In behavioral health services, social worker or social work consultants would be involved in care planning for patients because they help with primary care of these patients.
- Administrators will say "it is our policy that..." People are not allowed to see the policies and procedure, so they do not know them. Usually this is used to deny a resident something that they have asked for or take something away. Facilities should be clear about policies and procedures during the initial conversation about contract. Have a clear understanding about what's required at the outset so that people know what they are getting into

.10 Physician Services

- G (9) Specialty services - define "properly" in case there is disagreement about whether the attending physician is doing this and patient disagrees
- Add in electronic signatures when signing written orders.
- Assess new admission in "timely manner" - Can we be specific and say within 48 hour to get a treatment plan of some sort.
- Death Certificate - add in "including all information required by physician" in timely manner

.11 Medical Director Qualifications

- B (2) - add in having resident right to choose his or her own physician who is not on the facility's list

.11-1 Medical Director Responsibilities

- No Comments

.11-2 Facility's responsibilities in relation to medical director

- No Comments

.12 Nursing services

- Residents feel like there is not enough staff to respond to needs. Propose increase from 3 hours to 4+ hours per day to provide adequate care and response to patients.
- Staffing ratio needs to change because they cannot provide the time and care to patients - putting diapers on those who do not need it because they cannot get to the patients

- Budget problems prevent padding ratio of staff to patient. Can Medicaid cover the funding to provide what regs require?
- Who is involved in staffing ratio? GNAs, CNAs? If LPNs and RNs are included, be specific. If they are not included, patient care fails. Everyone in direct care should be included (includes upper level staff)
- 4.1 - 4.8 is the national standard to provide adequate care. We need to recognize this and realize our regs will probably not be addressed for a very long time and needs to address.
- Can regs be less stringent or provide for opportunity for family or retired medical professionals to come in and give some relief to direct care staff to attend trainings, meetings, etc.?
- 12 (J) ward clerk time - is it being counted at all? - OHCQ is taking this out. This is not being counted at all.
- Changing to comprehensive care requires RN in building 24 hours per day. How can this be expected?
- What does "prompt" mean? Any nursing staff should be able to provide dental hygiene assistance.
- Nursing facilities should have more ability to staff according to need. For example an extremely light-care facility doesn't need as much staff at a time than a high acute population.
- Restorative nursing care needs to go back into the regs. We need to find this language and place in the care plans for residents. This helps maintain success for a longer period of time. Restorative should not be optional if time permits because we already know time is not there.

C.) Wrap up comments

- Behavioral health care is a problem in the entire state of MD. There needs to be a better system in place in general.
- Thank you for inserting language around culture change

III. Next Steps

- Please use the survey tool to provide feedback (comments, recommendations, and/or suggestions). Only one submission permitted per organization or individual. The survey will remain open until Monday, October 13, 2014 at 5 p.m. OHCQ will respond to comments submitted through the survey tool.
- Visit our website for the link to be added to OHCQ's email list. (www.dhmh.maryland.gov/ohcq)

- Satisfaction survey will be provided in an email to the Long-term Care distribution list. This survey will collect feedback about the Long-term Care regulation review process.
- Meeting minutes will be posted on the website and OHCQ encourages anyone interested in receiving updates to join the email distribution list.